

DRUG ADDICTION: CRIME OR DISEASE? Interim and Final Reports of the Joint Committee of the American Bar Association and the American Medical Association on Narcotic Drugs. Bloomington: Indiana University Press, 1961. Pp. 173. \$2.95.

SOME five years ago the American Bar Association and the American Medical Association appointed a Joint Committee on Narcotic Drugs to explore the problem of drug addiction. The interim and final reports of this Joint Committee, together with two lengthy appendices to the interim report written by Judge Morris Ploscowe and Rufus King, form the main body of this book. Also included is a summary and recommendation of The Report on Narcotics Addiction by the Council on Mental Health of the American Medical Association (1956). An appropriate introduction by Alfred R. Lindesmith, a distinguished sociologist, prefaces these documents.

The two reports of the Joint Committee and the report of The Council on Mental Health consist largely of recommendations, and resemble one another in that, in the words of Dr. Lindesmith, they "reflect dissatisfaction with the operation of existing laws, . . . emphasize the medical rather than the punitive approach, . . . indicate a positive but cautious attitude toward the possibility of adopting British practices, and . . . stress above all the need for more investigation and for more reliable information." The statement of Judge Ploscowe is an eloquent argument for the position taken in the recommendations. The statement contributed by Rufus King, an eminent lawyer, is an appraisal of International, British, and selected European narcotic drug laws, regulations, and policies. It contains much that will be of interest to the student of the narcotic problem.

There is little that is new or original in the book. The Committee recommendations are not of great significance, notwithstanding the fact that they bear in a sense the prestige of the American Bar Association and the American Medical Association. They are based largely on knowledge gained from the behavioral sciences and reflect the caution that characterizes these sciences. The merit of the book lies primarily in the presentation of Judge Ploscowe and the light cast on the difference between the American and British approach to the problem by Rufus King. In his words:

The key to this difference appears to be that the British medical profession is in full and virtually unchallenged control of the distribution of drugs, and this includes distribution, by prescription or administration, to addicts when necessary. The police function is to aid and protect medical control, rather than to substitute for it.

Until 1914 there was virtually no legislative attempt in the United States to deal with the narcotic problem. In that year Congress enacted the Harrison Act, a revenue statute of a regulatory nature, designed to control the distri-

bution of narcotics. After World War I the Treasury Department was prevailed upon to urge a judicial interpretation of this Act as being prohibitory rather than regulatory in nature and as prohibiting the medical profession from ministering to the pathological problems of the drug addict where medical treatment involved the administration of drugs. This is the origin of the American approach to the problem.

The Treasury Department initially met with success in the courts. Two decisions of the Supreme Court of the United States, *Webb v. United States*¹ and *United States v. Behrman*,² both by a divided court, gave considerable support to this point of view. Regulations based on these decisions were drafted and the Treasury Department proceeded to prosecute many physicians.

In 1925, however, the Supreme Court reversed the conviction of a doctor under the Harrison Act in *Linder v. United States*.³ The Court, in a unanimous decision, distinguished its prior holdings and held in effect that the Act was not intended to interfere with the practice of medicine. The Court said at page 18:

Obviously, direct control of medical practice in the States is beyond the power of the Federal Government. Incidental regulation of such practice by Congress through a taxing act cannot extend to matters plainly inappropriate and unnecessary to reasonable enforcement of a revenue measure. The enactment under consideration levies a tax, upheld by this court . . . and may regulate medical practice in the States only so far as reasonably appropriate for or merely incidental to its enforcement. It says nothing of "addicts" and does not undertake to prescribe methods for their medical treatment. They are diseased and proper subjects for such treatment, and we cannot possibly conclude that a physician acted improperly or unwisely or for other than medical purposes solely because he has dispensed to one of them, in the ordinary course and in good faith, four small tablets of morphine or cocaine for relief of conditions incident to addiction.

Although the *Linder* case is obviously controlling, the Treasury Department continues to base its regulations and its policy on the *Webb* and *Behrman* cases. An indictment threatens any doctor who administers a quantity of drugs to an addict. Indictment may be followed by arrest, temporary detention, loss of license, and of course prolonged incarceration—and in any event the inevitable expense, embarrassment, and humiliation inherent in criminal litigation. As a result, the medical profession has virtually abandoned any attempt to treat the problem of drug addiction.

Since 1920 this policy of the Treasury Department—a policy at variance with the law as interpreted by the Supreme Court of the United States—has effectively denied the addict access to the medical practitioner and has left him

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1. 249 U.S. 96 (1919).
 2. 258 U.S. 280 (1922).
 3. 268 U.S. 5 (1925).

no recourse but to seek solace from the underworld. Organized crime, receiving its initial impetus from the 18th amendment, has been ready, able, and willing to fill the void created by the Treasury policy and has proceeded not only to furnish drugs to addicts but to use the addicts as pushers, the non-addict and real criminal entrepreneur being thereby largely shielded from detection.

While the Joint Committee and Judge Ploscowe are critical of the American approach to the problem and emphasize the medical rather than the punitive approach, they do not conclude that the addict should be taken care of either in a medical office, an institution, or a clinic. Reference is made to earlier clinical experience and the limitations of scientific knowledge regarding the treatment of drug addiction, and the conclusion drawn that, despite the absurdity of the present approach, there must be more research and more human knowledge before a change is embarked upon.

This is the point of view of an increasingly vocal minority who are intelligently critical of the current community approach to the problem of drug addiction. Their caution against action based on inadequate scientific data quite properly characterizes the behavioral and social scientist. It is to be questioned, however, whether this point of view is too restrained. The question is not one of urging a specific therapy for drug addiction. It is rather a question of the wisdom of *continuing* a prohibitory enforcement program. This and similar attempts to enforce standards of morality and social behavior by government prohibition historically have been unsuccessful. Logically, such an effort should be abandoned when experience indicates it is not enforceable, especially when it gives rise to greater evils than those it is intended to eradicate.

Judge Ploscowe's suggestion for implementing the *Linder* decision is also subject to question. He points out that under this decision the determination of whether the doctor acted in good faith and according to proper medical standards in prescribing a dosage of drugs must be submitted to a jury. He suggests that it would be more appropriate for the medical profession, through the American Bar Association, to lay down criteria by which a physician's treatment of a drug addict can be judged. Yet there is doubtful advantage in substituting for the fiat of a bureaucratic agency the fiat of organized medicine. It is apparent from this book itself that science is unable as yet to determine what is good medical practice in the treatment of an addict. At best, only the broadest rules can be prescribed. Actually, if there were an intelligent attitude on the part of the federal government, no doctor could quarrel with the fact that under appropriate circumstances a jury might be called upon to determine whether subjectively he acted in good faith. The difficulty is that under existing policy the question is whether objectively the doctor acted properly, and the Treasury Department maintains that this question

should be resolved against the doctor when his medical judgment involves the prescription of drugs.

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THE STRUGGLE FOR PENAL REFORM. By Gordon Rose. Chicago: Quadrangle Books, Inc., 1961. Pp. xii, 328. \$

THE English penal system has had a grim history and reforms have not come easily. The infamous hulks and the unbelievable cruelties of transportation were finally abandoned after much criticism in the 1850's, but a crime wave in the early 1860's brought tremendous pressures for renewed severity in the treatment of prisoners. The Howard Association, forerunner of today's Howard League for Penal Reform, was born in 1866. Its efforts to transform English prisons into places in which the prisoner could be rehabilitated rather than punished have been chronicled in meticulous detail by a member of the League's executive committee.

Sometimes the proponents of rehabilitation prevailed, sometimes not, but the ceaseless pressure that was maintained by the Howard Association for nearly one hundred years was a major factor in the reforms that were accomplished. The local prisons, 193 of them, all virtually autonomous when the Howard Association came into existence, were described in 1850 by a Select Committee of the Commons: "A harlequin's jacket is a consistent colour in comparison with the variety and discrepancies of the so-called systems which prevail in this country." By 1880 the prisons had been brought under centralized control. This was a necessary first step and facilitated the many later improvements that would have been impossible had the Association to deal with a multiplicity of systems.

The Association attempted initially to get the insane, the defectives, and the alcoholics out of the prisons. It succeeded to a degree with the first two and temporarily with the third, during the early 1900's. Reformatories were established for the treatment of alcoholics, but they were abandoned during the First World War for the very simple reason that no one knew how to cure a drunk. More notable successes were the establishment and subsequent refinement of the Borstal and probation systems as methods of dealing with offenders.

It was after the war that the Howard Association and the Penal Reform League merged into the Howard League for Penal Reform, and the strengthened organization pressed successfully for numerous prison improvements. In mar-

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